DEPARTMENT OF HUMAN SERVICES

INSTRUCTIONS FOR
TRANSFER FORM for MAINECARE MEMBERS ONLY

This transfer form communicates transfer of MaineCare members from one type of location to another and impacts reimbursement to providers.

Consumer Name: Enter the complete name of the consumer. First, MI, Last.

MaineCare Number: Enter 9 digit MaineCare number.

Facility Name: Enter your facility name. Do not enter a corporate company name.

Facility Telephone: Enter your facility phone number Facility Fax : Enter your facility fax number

Facility Contact Person: Enter name of contact person from your facility who may be contacted to discuss the transfer and status of this consumer.

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NEW ADMIT TO YOUR FACILITY (send only to Goold Fax # 1-800-368-0965) Date _____

Check this box and enter the date of admission of this consumer if he/she is a MaineCare member. Fax this to Goold. Upon receipt of this transfer form a conversion can be done on an Awaiting Placement assessment, which then will allow payment to your facility. To avoid payment problems, NFs must submit the Consumer transfer form to Goold on the date of admission or the next working day. Please keep a copy of the transfer form and verification, if submitted by fax (a fax print journal is best), to document that it has been forwarded to Goold.

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TRANSFERRED TO (send only to BMS-CR Fax # 287-6533 Do **NOT** send to BMS if **NOT** MaineCare member)

- ☐ Hospital: Bedhold Request (required if hospital stay > 24 hours-Sec 67.05-11B,C) Date _____

  Hospital name_____

If a resident will be in the hospital for more than 24 hours the nursing facility must request prior authorization for payment of bed reservations during a hospitalization. Payment for a semi-private room for a short-term hospitalization shall be granted up to 10 days (10 midnights), as long as the resident is expected to return to the nursing facility.

DEPARTMENT OF HUMAN SERVICES

INSTRUCTIONS FOR
TRANSFER FORM for MAINECARE MEMBERS ONLY (continued)

- ❑ Your nursing facility from hospital (Sec 67.05-11D) Date _____

Upon a resident's return from a hospital to your facility complete the above to indicate 'client return to NF' as described in Section 67.05-11D. Responsibility for informing the Department of dates of transfer rests solely with the NF since they know when a current resident has been transferred to and returns from the hospital.

Indicate by checking off either the "yes" or "no" boxes below if the consumer returned under the SNF benefit, or chose to waive their Medicare benefit. We have included 'Other' for those rare situations when a resident transfers and it involves a location other than hospital.

SNF Level of Care	YES	NO
Consumer waived Medicare	YES	NO

- ❑ Other _____

REMEMBER that a transfer from one NF to another NF is considered a discharge. Use the section below.

DISCHARGED TO (send only to BMS-CR Fax # 287-6533 Do **NOT** send to BMS if **NOT** a MaineCare member. Sec 67.05-9C.3)

This section is used to notify the Department of all MaineCare discharges on the day of discharge as described in Section 67.05-9C.3. It replaces the BMS/CS-34 'Notice of Consumer Transfer/Death'. It is also required of all Medicare discharges where MaineCare covers the copay, deductible, and/or coinsurance. Indicate the home address or facility name and date of discharge or date of death.

- ❑ Home Address_____ Date _____
- ❑ Residential Care (name) _____ Date _____
- ❑ Other Nursing Facility (name)_____ Date _____
- ❑ HHA (name) _____ Date _____
- ❑ Death Date _____
  End Hospice Status Date _____
- ❑ Deceased at Hospital Date _____

Person completing this form: _____

Please keep a copy of the transfer form and verification, if submitted by fax (a fax print journal is best), to document that it has been forwarded to BMS.